February 3, 2003

David Martinez
TWCC Medical Dispute Resolution
4000 IH 35 South, MS 48
Austin, TX 78704

MDR Tracking #: M2-03-0398-01
IRO #: 5251

___ has been certified by the Texas Department of Insurance as an Independent Review Organization. The Texas Worker's Compensation Commission has assigned this case to ___ for independent review in accordance with TWCC Rule 133.308 which allows for medical dispute resolution by an IRO.

___ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, all relevant medical records and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed.

The independent review was performed by a matched peer with the treating doctor. This case was reviewed by a licensed Medical Doctor with a specialty and board certification in Orthopedic Surgery. The ___ health care professional has signed a certification statement stating that no known conflicts of interest exist between the reviewer and any of the treating doctors or providers or any of the doctors or providers who reviewed the case for a determination prior to the referral to ___ for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

CLINICAL HISTORY

___ is a 45-year-old male who sustained injury to his neck and lower back while he was working on ___. The present dispute is over the cervical spine injury and the reviewer will confine his remarks to that area. The patient developed neck pain radiating down the right upper extremity in the work-related injury. He had conservative treatment that did not relieve his symptoms. He had a cervical MRI, which demonstrated evidence of nerve root impingement at C5-6 with degenerative disc disease at that level with some osteophpyte formation and disc herniation at the C5-6 level. It is true that he had other levels of degenerative disc disease, but this level was considered to be the most pronounced area of involvement. The patient was referred to ___ who is a spine surgeon. This referral was made because of the fact that conservative treatment did not relieve his symptoms and he was continuing to have severe neck pain, extremity pain and had neurological symptoms in his arms. ___ suggested a cervical myelogram and CT scan and also suggested electrodiagnostic studies of his upper extremities in order to evaluate the cervical spine problem. The electrodiagnostic studies were done and they demonstrated evidence of bilateral C6 radiculopathy. This would certainly correlate with the MRI finding of C5-6 nerve root compression and degenerative disc disease at that level.

The patient then underwent a CT scan myelogram on 9/17/02 at the ___ in ___. This CT myelogram demonstrated a severe spinal stenosis at C5-6 due to the osteophytosis and posterior protrusion of disc material at that level. There was some stenosis at C6-7, but C5-6 was felt to be the most severe level. He apparently has almost total non-filling of the nerve sleeve bilaterally at C5-6. He also had some stenosis of the nerve sleeve at C6-7, however, C5-6 is the primary noted level.

REQUESTED SERVICE

Cervical spinal surgery is requested for ___.

DECISION

The reviewer disagrees with the prior adverse determination.

BASIS FOR THE DECISION

With regards to this case, the patient has good correlation with all his findings at the C5-6 level. It appears that the patient is a candidate for anterior cervical fusion and disc removal at the C5-6 level. It is true that the patient has some diffuse degenerative changes, but this should not deter in the decision to have surgical treatment on his neck. The reviewer therefore finds that the surgical treatment that has been suggested by ___ is indicated on this patient.

___ has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. ___ has made no determinations regarding benefits available under the injured employee's policy.

As an officer of ___, I certify that there is no known conflict between the reviewer, ___ and/or any officer/employee of the IRO with any person or entity that is a party to the dispute.

___ is forwarding by mail and, in the case of time sensitive matters by facsimile, a copy of this finding to the treating doctor, payor and/or URA, patient and the TWCC.

Sincerely,

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the decision and has a right to request a hearing.

In the case of prospective ***spinal surgery*** decision, a request for a hearing must be made in writing and it must be received by the TWCC Chief Clerk of Proceedings within 10 days of your receipt of this decision. (20 Tex. Admin. Code 142.5(c)).

In the case of other ***prospective (preauthorization) medical necessity*** disputes a request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision (28 Tex. Admin. Code 148.3).

This decision is deemed received by you 5 (five) days after it was mailed (28 Tex. Admin. Code 102.4(h) or 102.5(d). A request for a hearing should be sent to: Chief Clerk of Proceedings, Texas Worker's Compensation Commission, P.O. Box 40669, Austin, TX 78704-0012. A copy of this decision should be attached to the request.

The party appealing this decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute, per TWCC rule 133.308(t)(2).